CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

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INTRODUCTION

In 1986 Public Law 99-272 (COBRA) was enacted. Section 9508(a)(1) allows a state to provide case management services that will assist recipients in gaining access to medical, social, educational and other services. Section 9501(b) of COBRA provides an exception to the requirement that services be comparable for all Medicaid recipients by allowing additional services available only to pregnant women. These services may be preventive/curative services including patient education and nutritional counseling. In 1988, the Virginia General Assembly gave the Department of Medical Assistance Services authority to implement these additional services in order to promote better pregnancy outcomes through the provision of a coordinated network of maternal health care services. These services are referred to as "BABYCARE."

The primary reason for including BabyCare services in the Medicaid Program is to remove two major barriers that negatively affect pregnancy outcomes: (1) fragmentation and lack of coordination in service delivery and; (2) lack of patient knowledge of and ability to successfully access the health care system.

High-risk pregnant women and infants need a combination of medical and non-medical services to ensure a healthy and successful pregnancy outcome. Since many of these recipients have a difficult time getting through the service network, care coordinators must assure that recipients will actually receive the necessary health care services.

The major goals of the BabyCare Program are to:

1. Reduce infant mortality and morbidity;
2. Ensure provision of comprehensive services to pregnant women and infants up to age two; and
3. Assist pregnant women and caretakers of infants in meeting other priority needs that affect their well-being and that of their families.

GENERAL PROVIDER PARTICIPATION STANDARDS

All providers enrolled in the Medicaid Program must adhere to the conditions of participation outlined in their individual provider agreements. Providers approved for participation in the Medical Assistance Program must perform the following activities as well as any others specified by DMAS:

- Immediately notify the Provider Enrollment/Certification Unit of the Department of Medical Assistance Services, in writing, of any change in the information which the provider previously submitted to the Department;

- Ensure freedom of choice to recipients in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in the Medicaid Program at the time the service was performed. Providers who are unable to render needed services to recipients should refer them to another provider;

- Ensure the recipient's freedom to reject medical care and treatment;

- Provide services and supplies to recipients in full compliance with Title VI of the Civil Rights Act of 1964 which prohibits discrimination on the grounds of race, color, religion, or national origin;

- Provide services and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973 requiring that all necessary accommodations be made to meet the needs of persons with semi-ambulatory disabilities, sight and hearing disabilities, and disabilities of coordination (refer to the section regarding the Rehabilitation Act);

- Provide services and supplies to recipients in the same quality and mode of delivery as provided to the general public;

- Charge the Department of Medical Assistance Services for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public;

- Accept as payment in full the amount reimbursed by the Department of Medical Assistance Services. 42 CFR, Section 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the State. The provider should not attempt to collect from the recipient or the recipient's responsible relative(s) any amount that exceeds the usual Medicaid allowance for the service rendered. For example: If a third party payer reimburses $5.00 out of an $8.00 charge, and Medicaid's allowance is $5.00, then payment in full of the Medicaid allowance has been made. The provider may not attempt to collect the $3.00 difference from Medicaid, the recipient, a spouse, or a responsible relative;

- Accept assignment of Medicare benefits for eligible Medicaid recipients;

- Use Program-designated billing forms for the submission of charges;

- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. (Refer to the sections regarding documentation of records in this chapter.)

- Such records must be retained for a period of not less than five years from the date of service or as provided by applicable state laws, whichever period is longer. If an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved;

- Furnish to authorized State and federal personnel, in the form and manner requested, access to records and facilities;

- Disclose, as requested by the Department of Medical Assistance Services, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of medical assistance; and

- Hold information regarding recipients confidential. Information may be shared with other health-care providers only when the care coordinator has a signed release from the recipient. A provider shall disclose information in his or her possession without a separate release only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of the State Agency. The State Agency shall not disclose individual recipient medical information to the public.

MATERNAL AND INFANT CARE COORDINATION

Provider Participation Standards

Maternal and infant care coordination providers may be community health centers, local health departments, rural health clinics, home health agencies, personal care agencies, physicians, outpatient hospitals, and local departments of social services which have signed an agreement with the Department of Medical Assistance Services.

A maternal and infant care coordinator (MICC) is a Registered Nurse (RN) or Social Worker (SW) employed by a qualified service provider who provides care coordination services to eligible recipients. The RN must be licensed in Virginia and should have a minimum of one year of experience in community health nursing and experience in working with pregnant women and infants. The social worker must have an M.S.W. or a B.S.W. degree and a minimum of one year of experience in a health care setting working with pregnant women and their families. The maternal and infant care coordinator is a health professional who assists recipients in accessing the health care and social service system in order to promote both physical and mental health.

Provider Participation Requirements

In addition to the general provider participation requirements, providers contracting to provide maternal and infant care coordination must agree to provide all of the following services:

Risk Screen

The risk screen is designed to capture high-risk pregnant women and infants identified by the BabyCare Program. Risks must not be altered. Check all risks that apply to the recipient. The physician, certified nurse midwife or nurse practitioner is responsible for filling out the risk screen.

Each risk identified on the risk screen should be addressed in the service plan.

In the process of completing the assessment, the maternal and infant care coordinator can identify additional risks by placing his or her initials by the risk identified.

Assessment

Determining the recipient's service needs through a comprehensive appraisal of his or her current health, nutritional, psychological, social, environmental, economic and demographic status to develop an individual plan of care. The care coordinator must complete the patient care assessment completely on each individual enrolled.

The assessment must result in the identification of problems having an impact on the success of the pregnancy or the health care status of the infant. Each problem identified must be addressed in the service plan or significant findings area of the care coordination record.

Service Planning

Developing an individualized plan of care describing the services and resources needed to meet the recipient's needs identified through the assessment, including a description of the specific action steps necessary to meet each identified need. Each risk identified on the risk screen should be addressed in the service plan. The plan should be mutually agreed to with the recipient. Services provided should be above and beyond routine care.

Coordination and Referral

Assisting the recipient in arranging for appropriate services and ensuring the continuity of care by referring the recipient to suitable service providers. Assisting the recipient in obtaining and keeping appointments, arranging transportation, and understanding the information the provider may require.

Follow-Up and Monitoring

Assessing ongoing progress and ensuring services are delivered; maintaining contact with the service providers to assure that the recipient keeps appointments and understands and complies with the plan of care or any other requirements of the service providers.

Education and Counseling

Guiding the client and developing a supportive relationship which:

- Promotes the recipient's participation in the service plan;
- Enhances the recipient's independence and self-sufficiency toward the goal of a successful pregnancy; and
- Helps the mother access needed medical and other appropriate services for her infant.

Documentation Requirements

The provider agreement requires that records fully disclose the extent of services provided to Medicaid recipients. These records must be available for inspection for at least five years.

The following elements describe the Medicaid policy regarding documentation of records:

- The maternal and infant care coordinator (MICC) documentation must be clearly identified as MICC services in records where other types of clinic services are offered;
- All MICC interventions, such as therapeutic measures, education and referrals, must be documented in the MICC record;
- The record must identify the MICC recipient on each entry;
- All contacts with recipients or related to the recipient must be entered in the record and signed by the individual providing the service;
- An entry specifying the service provided must be written for each procedure code listed on the invoice;
- A copy of the risk screen/referral form completed by the recipient's primary care provider must be retained in each recipient's record; and
- The required forms for the Maternal and Infant Care Coordination Record and Service Plan found in Chapter IV, Exhibits IV.3-8, must be filed in the medical record.

PATIENT EDUCATION

Provider Participation Standards

Providers may have courses and patient education instructors approved for Medicaid reimbursement. The patient education courses that can be offered to a recipient are smoking cessation classes, childbirth classes and parenting classes.

To qualify for reimbursement, a patient education instructor may complete the American Red Cross Instructor Candidate Training (ICT) Course and program-specific training. This six-hour training session is available throughout Virginia. Interested candidates should contact their local American Red Cross Chapter for specific training dates and class location.

Other Medicaid-approved instructor certification programs include, but are not limited to, the following: The International Childbirth Educators Association (ICEA) or the Richmond Childbirth Educators Association (RCEA), the American Society for Psychoprophylaxes in Obstetrics (ASPO), or the American Lung Association (ALA).

Instructors who have completed any of the approved certification courses listed should maintain a copy of the certificate in the instructor's personnel file at the agency.

Instructors who have certification from other programs may forward their course content and a copy of the certificate to DMAS. The course should meet the following criteria:

INSTRUCTOR CERTIFICATION STANDARDS

- Patient education must be rendered by certified providers who have appropriate education, license, or certification;
- The instructor should have completed a formalized course given by a recognized accredited health care organization or education-related agency which may be community- or hospital-based;
- Instructor training must be a formal course of study based on an established, written curriculum;
- Instructor training must include principles of teaching, adult learning and group education as well as content specific to the type of certification (e.g., preparation for childbirth, preparation for parenting, smoking cessation); and
- Mechanisms for practice teaching and/or observed teaching practicum should be included.

Following DMAS review of the course content, a letter of approval/denial will be sent to the provider agency. A copy of this letter must be retained in the instructor's personnel file.

PROGRAM CERTIFICATION STANDARDS

Providers who wish to have childbirth, parenting, or smoking cessation programs approved for Medicaid reimbursement should forward the detailed course content, length of classes, and instructor certification to DMAS. Courses should meet criteria similar to those listed in Appendix C, Patient Education Course Contents. All required documentation may be sent to the following address:

Department of Medical Assistance Services
Community-Based Care - ATTN: BabyCare
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Following DMAS review of the program content, a letter of approval/denial will be sent to the provider agency. A copy of this letter must be retained in the provider file.

Provider Participation Requirements

This service includes six sessions of group education for pregnant women in the following courses: Preparation for Childbirth, Preparation for Parenthood and Smoking Cessation.

Patient education must be rendered by Medicaid-enrolled providers and taught by a certified instructor in a group session. Coverage is limited to one course of six classes which best meets the needs of individual recipients in reaching the goal of a successful pregnancy.

Documentation Requirements

A written record must be kept identifying the instructor and course completed. There also must be verification of attendance at each session by the recipient's signature.

NUTRITIONAL SERVICES

Provider Participation Standards

This service includes nutritional assessment of dietary habits and nutritional counseling and counseling follow-up. These services are in addition to the basic nutritional information that all pregnant women are expected to receive through their medical care provider or the WIC program. Nutritional education and special diet information are included when appropriate.

These services must be rendered by a Registered Dietitian (R.D.) or person with a masters degree in nutrition or clinical dietetics. Both require experience in public health, maternal and child nutrition or clinical dietetics.

Provider Participation Requirements

The initial orientation and periodic follow-up will include instructions concerning basic nutrition during pregnancy, referral and linkage with WIC, ongoing focus on gestationally appropriate weight gain, dietary intake and special diet information. The Medicaid Program will reimburse a provider for the initial nutritional assessment and follow-up visits which may not exceed two.

Criteria for referral to nutritional prenatal care services are prepregnancy underweight/overweight, inadequate or excessive weight gain, a teenager 18 years of age or younger, poor diet, pica, an obstetrical or medical condition requiring diet modification such as multiple gestation, delayed uterine growth, diabetes, anemia, etc.

Documentation Requirements

1. **Nutritional Assessment** - The provider of nutritional services must have a written dietary assessment for each recipient which will include: height and weight measurements including pregravid weight, laboratory values, dietary habits, socioeconomic status, nutritional counseling, complications of pregnancy involving a nutritional component and a plan for follow-up and referral based on individual needs. Documentation of participation in food assistance programs such as WIC or Food Stamps should also be included. It is acceptable to maintain laboratory values in the record laboratory section if the agency so desires.

2. **Nutritional Follow-Up Visits** - Any concerns found in the initial assessment must be addressed in the progress notes for the follow-up visits.

HOMEMAKER SERVICES

Provider Participation Standards

Homemaker services includes those services necessary to maintain household routine for pregnant and postpartum women when bed rest is necessary as ordered by a physician. Homemaker services must be rendered by an agency with a history of successful community care provisions. The homemaker agency must employ an RN or LPN who will provide supervision to the homemaker aides. The homemaker duties may be performed by a companion, homemaker, nursing assistant or home health aide.

Provider Participation Requirements

The criterion for this service is bed rest ordered by a physician for a specific time period. Services may be covered up to 31 days.

Homemaker services may be extended beyond 31 days if the recipient continues to require bed rest. Preauthorization for payment of the extended services must be obtained from DMAS.

To receive authorization for an extension of services, the MICC must submit to DMAS a copy of a letter from the physician. The following information should be included in the physician's letter:

(1) The recipient's name and current Medicaid I.D. number;

(2) A brief medical justification for the continued need for bed rest (e.g., placenta previa, preterm labor); and

(3) The expected amount of time that the recipient will continue bed rest.

A copy of the medical necessity letter should be forwarded to the following address:

Department of Medical Assistance Services
Community Based Care - ATTN: BabyCare
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Following review of the medical necessity letter, DMAS will forward to the MICC a letter authorizing further reimbursement for homemaker services.

Documentation Requirements

Documentation for homemaker services must include a written order from the physician supervising the recipient's prenatal and/or postpartum care which states that the recipient is confined to bed for a specific period of time. There must be documentation of an assessment performed by the supervisor of the homemaker service which states what services are required for the normal functioning of the bed-bound recipient's household. The assessment should reflect inquiries into such elements as: the number and age of persons in the household, availability of assistance by relatives/friends, needs as perceived by the bed-bound recipient, etc. Based on the needs assessment, there must be documentation of a plan of care that states which specific service(s) is needed and how often it is to be rendered. All documentation for the extension of services should be retained in the record.

The services rendered and length of the visit by the homemaker services aide must be documented and signed by the aide and the recipient of services for each date of service.

Homemaker services rendered must be reviewed monthly by the supervisor and documented in the record. Flow sheets may be utilized by the homemaker and/or the supervisor for documentation purposes.

PROVIDER ENROLLMENT

Any provider of services must be enrolled in the Medicaid Program prior to billing for any services provided to Medicaid recipients. A copy of the provider agreement can be found at the end of this chapter. All providers must sign the appropriate Participation Agreement and return it to the Provider Enrollment and Certification Unit; an original signature of the individual provider is required. The agreement is time-limited and applies to a specific time period. All participants are required to complete new agreement forms when a name change or change of ownership occurs.

Upon receipt of the above information, a seven-digit Medicaid identification number is assigned to each approved provider. This number must be used on all claims and correspondence submitted to Medicaid.

This manual contains instructions for billing and specific details concerning the Medicaid Program. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

REQUESTS FOR PARTICIPATION

To become a Medicaid provider of services, the provider must request a participation agreement by writing:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 provides that no handicapped individual shall, solely by reason of the handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each Medicaid provider is responsible for making provisions for handicapped individuals in his or her program activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. By signing the check, the provider indicates compliance with Section 504 of the Rehabilitation Act.

In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements.

UTILIZATION OF INSURANCE BENEFITS

The Virginia Medical Assistance Program is a "last pay" program. Benefits available under Medical Assistance shall be reduced to the extent that they are available through other federal, State, or local programs; coverage provided under federal or State law; other insurance; or third-party liability.

Health, hospital, Workers' Compensation, or accident insurance benefits shall be used to the fullest extent in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

- **Title XVIII (Medicare)** - Virginia Medicaid will pay the amount of any deductible or coinsurance for covered health care benefits under Title XVIII of the Social Security Act for all eligible persons covered by Medicare and Medicaid.

- **Workers' Compensation** - No Medicaid Program payments shall be made for a patient covered by Workers' Compensation.

- **Other Health Insurance** - When a recipient has other health insurance (such as CHAMPUS, Blue Cross-Blue Shield, or Medicare), Medicaid requires that these benefits be used first. Supplementation shall be made by the Medicaid Program when necessary, but the combined total payment from all insurance shall not exceed the amount payable under Medicaid had there been no other insurance.

- **Liability Insurance for Accidental Injuries** - The Virginia Medicaid Program will seek repayment from any settlements or judgments in favor of Medicaid recipients who receive medical care as the result of the negligence of another. If a recipient is treated as the result of an accident and the Virginia Medical Assistance Program is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to establish a lien as set forth in the Virginia Code Section 8.01-66.9. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing Medicaid.

  In the case of an accident in which there is a possibility of third-party liability or if the recipient reports a third-party responsibility (other than those cited on his or her Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the physician is requested to forward the DMAS-1000 to:

  Third-Party Liability Casualty Unit
  Virginia Medical Assistance Program
  600 East Broad Street
  Richmond, Virginia 23219

A copy of this form is included at the end of this chapter (Exhibit II.2).

TERMINATION OF PROVIDER PARTICIPATION

The participation agreement will be time-limited with periodic renewals required. DMAS will request a renewal of the Participation Agreement prior to its expiration.

A participating provider may terminate his or her participation in Medicaid at any time. The Director, Department of Medical Assistance Services, should receive written notification 30 days prior to the effective date.

DMAS may terminate a provider from participation upon written notification 30 days prior to the effective date. Such action precludes further payment by DMAS for services

provided recipients subsequent to the date specified in the termination notice.

The Code of Virginia, Chapter 10, Department of Medical Assistance Services, Section 32.1-325(c), mandates that "Any such (Medicaid) agreement or contract shall terminate upon conviction of the provider of a felony."

A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify the Program of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of State law.

RECONSIDERATION OF ADVERSE ACTIONS

The following procedures will be available to all providers when DMAS takes adverse action which includes termination or suspension of the provider agreement.

The reconsideration process will consist of three phases: a written response and reconsideration to the preliminary findings, the informal conference, and the formal evidentiary hearing. The provider will have 30 days to submit information for written reconsideration and will have 15 days' notice to request the informal conference and/or the formal evidentiary hearing.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (Section 9-6.14:1 et seq.) and the State Plan for Medical Assistance provided for in Section 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the Administrative Process Act.

Any legal representative of a provider must be duly licensed to practice in the Commonwealth of Virginia.

Repayment of Identified Overpayments

Pursuant to Section 32.1-325.1 of the Code of Virginia, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When a lump sum cash payment is not made, interest will be added on the declining balance at the statutory rate, pursuant to the Code of Virginia, Section 32.1-313.1. Interest will not apply pending appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates to the satisfaction of DMAS a financial hardship warranting extended repayment terms.

PROVIDER APPEALS OF DENIAL OF PAYMENT

Non-State Operated Provider

Any denial of payment decisions concerning covered services made by DMAS staff may be appealed to the Department of Medical Assistance Services. Written reconsideration

must be filed within 30 days of the date of the final decision notification and should be directed to:

Manager, Home and Community-Based Care Section
Division of Quality Care Assurance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

If the reconsideration is denied, the provider may submit a written request for an informal meeting with DMAS staff. The request should be addressed to Manager, Long-Term Care Section, at the above address. If the provider is not satisfied with the results from the informal meeting, the provider may submit a written request for an evidentiary hearing. This request must be submitted to:

Director, Division of Quality Care Assurance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

A provider cannot bill a recipient for services if the services are not covered by Medicaid due to the provider's failure to obtain preauthorization or to perform other required administrative functions.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement and denial of payment for services rendered based on utilization review decisions. State-operated provider means a provider of Medicaid services which is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration for any issue which would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: an informal review by the Division Director, DMAS Director review, and Secretarial review. First, the state-operated provider will submit to the appropriate DMAS Division written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives its Notice of Amount of Program Reimbursement, notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought; the amount of the adjustment sought; and the reasons for seeking the adjustment. The Division Director will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution. The Division Director will consider the request and render a decision.

A state-operated provider may, within 30 days after receiving the informal review decision of the Division Director, request that the DMAS Director or his designee review the decision of the Division Director. The DMAS Director has the authority to take whatever measures he deems appropriate to resolve the dispute.

If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 days after receipt of the decision of the DMAS Director, the provider may request the DMAS Director to refer the matter to the Secretary of Health and Human Resources or any other Cabinet Secretary as appropriate. Any determination by such Secretary or Secretaries will be final.

EXHIBIT II.1

PARTICIPATION AGREEMENT, DMAS-112

Medicaid Provider Number _____

Commonwealth of Virginia
Department of Medical Assistance Services
Medical Assistance Program
Expanded Prenatal Care/Maternity and Infant Care Coordination
Participation Agreement

This is to certify that _____/_____
(Name of Provider) (Name of Facility)

of _____, _____, _____
(Street Address) (City & State) (Zip Code)

on this ____ day of _____, 19__ agrees to participate in the Virginia Medical Assistance Program (VMAP).

Provider payments and information should be sent to _____
(Name)

of _____, _____, _____ if different from above.
(Street Address) (City & State) (Zip Code)

1. The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended and is not as a matter of state or federal law disqualified from participation in this program.

2. The provider will provide the services checked below as described:

|__| I agree to provide care coordination. Services will be rendered only by a registered nurse (R.N.) or a social worker (M.S.W. or B.S.W.). The RN must be licensed in Virginia and have a minimum of one year experience in community health nursing and experience in working with pregnant women. The social worker must have a minimum of one year experience in health and human services and have experience in working with pregnant women and their families.

|__| I agree to provide nutritional services. These services will be rendered only by registered dietitians (R.D.) having experience in public health, maternal and child nutrition or clinical dietetics.

|__| I agree to provide patient education services. These services will be rendered only by individuals certified by one of the following: the International Childbirth Educators Association, the Richmond Childbirth Educators Association, the America Society for Psychoprophylaxes in Obstetrics, the American Red Cross or the American Lung Association.

|__| I agree to provide homemaker services. This service will be provided by a certified homemaker/home health aide.

3. Services will be provided without regard to race, color, religion, or national origin. No handicapped individual shall, solely by reason of handicap, be excluded from participation in, denied the benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of 1973, 29 USC 706) VMAP.

4. The provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the state plan. Access to records and facilities by authorized VMAP representatives, the Attorney General of Virginia or his authorized representatives, and authorized federal personnel will be permitted upon reasonable request.

5. The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.

EXHIBIT II.1 (continued)

PARTICIPATION AGREEMENT, DMAS-112

6. Payment made under VMAP constitutes full payment on behalf of the recipient except for patient pay amounts determined by VMAP, and the provider agrees not to submit additional charges to the recipient for services covered under VMAP. The collection or receipt of any money, gift, donation of other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited and may subject the provider to federal or state prosecution.

7. The provider agrees to pursue all other health care resources of payment prior to submitting a claim to VMA

8. Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.

9. This agreement may be terminated at will on thirty days' written notice by either party.

10. All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant t the Virginia Administrative Process Act.

11. This agreement shall commence on _____ and terminate on _____.
(To Be Completed By Medicaid)

PROVIDER SERVICES:

by: _____ Title _____ Date _____
(Signature of Provider)

_____
Employer's ID or Social Security Number

____ City or ____ County of _____ (_____) _____
Area Code Telephone No.

DO NOT USE

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES:

by: _____ _____
Signature Date

_____ Director, Division of Operations and Provider Services
Title

Mail two completed copies to:

Provider Enrollment/Certification Unit
Department of Medical Assistance Services
Suite 1300
600 East Broad Street
Richmond, Virginia 23219

EXHIBIT II.2

THIRD PARTY LIABILITY INFORMATION REPORT -, DMAS-1000

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

EMERGENCY MEDICAL CERTIFICATION

FROM:

I. REFERRAL SECTION

TO: SUPERVISOR, DIVISION OF HEALTH SERVICES REVIEW
DEPT. OF MEDICAL ASSISTANCE SERVICES
600 EAST BROAD STREET, SUITE 1300
RICHMOND, VA 23219

APPLICANT NAME: _____

CASE NUMBER: _____

THE ABOVE-NAMED INDIVIDUAL IS A NON-RESIDENT ALIEN WHO HAS APPLIED FOR MEDICAID. A DETERMINATION OF EMERGENCY NEED AND DURATION IS NEEDED NO LATER THAN _____ (DATE). ATTACHED IS INFORMATION ON THE EMERGENCY MEDICAL TREATMENT.

SIGNED: _____ WORKER # _____ DATE: _____

II. CERTIFICATION SECTION

I HAVE REVIEWED THE MEDICAL EVIDENCE AND DETERMINE THAT THE MEDICAL CONDITION

☐ IS AN EMERGENCY. ☐ IS NOT AN EMERGENCY.

THE REASON FOR DETERMINATION, OR SPECIFICS OF COVERED SERVICES AND DURATION OF COVERAGE ARE DETAILED BELOW.

SIGNED: _____ TITLE: _____ DATE: _____

III. NOTIFICATION SECTION

TO: MEDICAID SERVICE PROVIDERS

☐ THE ABOVE-NAMED INDIVIDUAL HAS BEEN DETERMINED INELIGIBLE FOR MEDICAID BENEFITS. REASON FOR DENIAL: _____

☐ THE ABOVE-NAMED INDIVIDUAL IS ELIGIBLE FOR MEDICAID TO COVER EMERGENCY SERVICES. ONLY SERVICES DIRECTLY RELATED TO THE EMERGENCY ARE COVERED FOR THE TIME PERIOD SPECIFIED BELOW. THIS FORM SERVES AS YOUR NOTIFICATION OF ELIGIBILITY IN LIEU OF A MEDICAID CARD. IF YOU HAVE ANY QUESTIONS, CALL THE PROVIDER HELPLINE AT 1-800-552-8627.

PERIOD OF COVERAGE: _____

MEDICAID NUMBER: _____

OTHER INSURANCE: _____

SIGNED: _____ TITLE: _____ DATE: _____

032-03-628/1 (11/87)

LOCAL AGENCY